

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 03-012B	2. STATE Kentucky
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE November 1, 2003	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: 1902 (n) of the Social Security Act	7. FEDERAL BUDGET IMPACT: a. FFY 2004 \$ (.64 million) b. FFY 2005 \$ (.70 million)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D Pages 6 & 9; Attachment 4.19-D Exhibit B Pages 1, 6, 7, 10, 11, 16, 18, 20, 21.	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-D Pages 6 & 9; Attachment 4.19-D Exhibit B Pages 1, 6, 7, 10, 11, 16, 18, 19, 20, 21, 21-D, 21-E, 21-F & 21-G.

10. SUBJECT OF AMENDMENT:
Payment of Medicare Part B deductible/coinsurance for ancillary services in nursing facilities and reimbursement of ancillary services for price-based nursing facilities.

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☒ OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: <i>Mike Robinson</i>	16. RETURN TO: Frances McGraw Eligibility Policy Branch Department for Medicaid Services 275 East Main Street 6W-C Frankfort, Kentucky 40621
13. TYPED NAME: Mike Robinson	
14. TITLE: Commissioner, Department for Medicaid Services	
15. DATE SUBMITTED: 11/05/04	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: DEC 15 2003	18. DATE APPROVED: July 28, 2004
19. EXECUTIVE DETERMINATION OF APPROVED MATERIAL: NOV - 1 2003	20. SIGNATURE OF REGIONAL OFFICIAL: <i>Barbara A. Smith</i>
21. TYPED NAME: DENNIS G. Smith	22. TITLE: DIRECTOR, CMSO

Beginning April 2, 2001 and ending June 30, 2005, subject to the availability of funds, the Department will make supplemental payments to qualifying nursing facilities on a quarterly basis. The Department will use the following methodology to determine these payments:

- 1) For each state fiscal year, the Department will calculate the maximum addition payments that it can make to non-state government-owned or operated nursing facilities as set forth at 42 CFR Section 447.272 (a)(2) and 42 CFR Section 447.272 (b).
- 2) The Department will use the latest cost report data on file with the Department as of December 31, 2000 to identify the nursing facilities eligible for supplemental payments. To be eligible for supplemental payments the nursing facility must:
 - a) Be a nursing facility owned or operated by a local unit of government;
 - b) Have at least 140 or more Medicaid certified beds; and
 - c) Have Medicaid occupancy at or above 75%.

A qualifying nursing facility is an eligible facility that is owned or operated by a local unit of government that has entered into an Intergovernmental Transfer Agreement with the Commonwealth.

- 3) The Department will determine the amount of supplemental payments it will make to qualifying nursing facilities in a manner not to exceed the upper limit amount as calculated in 1 above.
- 4) Using the cost report data on file as of December 31, 2000, the Department will identify the total Medicaid days reported by the qualifying nursing facilities as identified in 2 above.
- 5) The Department will divide the total Medicaid days for each qualifying county-owned or operated nursing facility as determined in 2 above by the total Medicaid days for all qualifying facilities to determine the payment supplementation factor.
- 6) The Department will apply each qualifying county-owned or operated nursing facility's payment supplementation factor determined in 5 above to the total supplemental payment amount identified in 3 above to determine the payment to be made to each qualifying nursing facility.

SECTION 5. SCHEDULE NF- 8 – MISCELLANEOUS INFORMATION

All providers must complete section A and B.

- A. A NF shall submit a Medicare cost report and Medicaid supplement schedule pursuant to HCFA Provider Reimbursement Manual – Part 2 (Pub. 15-11) Section 102, 102.1, 102.3 and 104 included in this manual.
- B. A copy of a NF's Medicare cost report for the most recent fiscal year end.
- C. A completed copy of the Medicaid supplemental schedules included in this manual shall also be submitted with the NF's Medicare cost report.
- D. A cost report's financial data related to routine services shall be used for statistical purposes.

SECTION 4. SCHEDULE NF- 7 – ALLOCATION STATISTICS

A. Section A – Ancillary Charges

1. Column 1. Enter the total charges for each type of ancillary service on Line 1 through 6. The sum of lines 1 through 6 are totaled on line 7.
2. Column 2. Enter the total charges for each type of ancillary service provided to KMAP patients in certified beds on lines 1 through 6. Lines 1 through 6 a summed and totaled on line 7.
3. Column 3. The Medicaid percentage in column 3 is calculated by dividing KMAP charges in column 2 by total charges in column 1. Percentages shall be carried to four decimal places (*i.e.*, XX.XXXX%).

B. Section B – Occupancy Statistics.
Certified Nursing Facility. Use the Bed Days Available worksheet on Box C to complete lines 1, 2, and 3. For line 4, enter in the Total Patient Days provided to all certified nursing facility residents. On line 6, enter in the KMAP Patient Days.

C. Non-Certified and Other Long-Term Care

1. Lines 1 and 2. Enter the number of licensed beds at the beginning and end of the fiscal year. Temporary changes due to alterations, painting, etc., do not affect bed capacity.
2. Line 3. Total licensed bed days available shall be determined by multiplying the number of beds in the period by the number of days in the period. Take into account increases and decreases in the number of licensed beds and the number of days elapsed since the changes. If actual bed days are greater than licensed bed days available, use actual bed days.
3. Line 4. Total patient days should be entered in.

SECTION 3. SCHEDULE NF- 3- STAFF INFORMATION

On an annual basis the Department for Medicaid Services shall select a seven-day period in which the facility records information regarding their staffing levels and patient days.

- A. Record the number of residents in your facility in the Resident Census section. This includes *only* those full-time residents in the certified nursing facility section.
- B. For each of the staff categories, record the number of staff on duty. Contract staff should be included in this category.
- C. Continue this throughout the seven-day survey period.

SECTION 190. ANCILLARY SERVICES

- A. The department shall reimburse for an ancillary service that meets the criteria established in 907 KAR 1:023 utilizing the corresponding outpatient procedure code rate listed in the Medicaid Physicians Resource Based Relative Value Scale fee schedule.
- B. The department shall reimburse for an oxygen therapy utilizing the durable medical equipment fee schedule.
- C. Respiratory therapy and respiratory therapy supplies shall be considered in the routine services per diem rate.
- D. The department shall calculate an add-on amount in accordance with 907 KAR 1:065, Section 12, to be in effect from November 1, 2003 through June 30, 2004, to a nursing facility's routine services per diem rate if the nursing facility incurred cost providing respiratory therapy or respiratory therapy supplies for the period July 1, 2003 through September 30, 2003.
- E. A nursing facility shall submit documentation requested by the department in order to apply for a routine services per diem add-on in accordance with 907 KAR 1:065, Section 12.

SECTION 200. REIMBURSEMENT REVIEW AND APPEAL

A NF may Appeal department decisions as to the application of this regulation as it impacts the NF's price-based reimbursement rate in accordance with 907 KAR 1:671, Section 8 and 9.

240 and then multiplying the result of this division by the Medicare Part B maximum charge. For example, if a concentrator is used less than 220 hours during a thirty (30) day month and the maximum Part B allowable charge is \$250.00; then the allowable charge is computed by dividing the 220 hours by 240 hours and then multiplying the product of this division by \$250.00 to obtain the allowable charge of \$229.17. Allowable oxygen costs outlined in this paragraph shall be considered to be ancillary costs.

2. A facility shall be limited to one (1) standby oxygen concentrator for each nurses' station. The Medicaid Services Program may grant waivers of this limit. This expense shall be considered as a routine nursing expense for any month in which there is no actual use of the equipment. The allowable cost for standby oxygen concentrators shall be limited to twenty-five (25) percent of the maximum allowable payment under Medicare Part B for in home use.

NOTE: Drugs for residents in nursing facilities shall be reimbursed through the pharmacy program.

L. The department shall adjust the Standard Price if:

1. A government entity imposes a mandatory minimum wage or staffing ratio increase and the increase was not included in the DRI; or
2. A new licensure requirement or new interpretation of an existing requirement by the state survey agency that results in changes that affect all facilities within the class. The provider shall document

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- H. The capital cost component shall be an "add-on" to the "non case-mix" adjusted portion of the rate. The capital cost component shall be adjusted each July 1 by the inflation factor found in the R. S. Means Construction Index.
- I. Ancillaries are services for which a separate charge is submitted and includes:
1. Speech Therapy
 2. Occupational Therapy
 3. Physical Therapy
 4. Oxygen Services
 5. Laboratory
 6. X-ray
- J. Ancillary therapy services are reimbursed pursuant to 907 KAR 1:023.
- K. Oxygen concentrator limitations. Effective October 1, 1991, the allowable cost of oxygen concentrator rentals shall be limited as follows:
1. A facility may assign a separate concentrator to any resident who has needed oxygen during the prior or current month and for whom there is a doctor's standing order for oxygen. For the charge by an outside supplier to be considered as an allowable cost, the charge shall be based upon actual usage. A minimum charge by an outside supplier is allowable if this charge does not exceed twenty-five (25) percent of the Medicare Part B maximum. The minimum charge is allowable if the concentrator is used less than an average of two (2) hours per day during the entire month (for example, less than 60 hours during a thirty (30) day month). The maximum allowable charge by the outside supplier shall not exceed one hundred (100) percent of the Medicare Part B maximum. For the maximum charge to a facility to be considered as the allowable cost, the concentrator shall have been used on average for a period of at least eight (8) hours per day for the entire month (for example, 240 hours during a thirty (30) day month). In those cases where the usage exceeds that necessary for the minimum charge and is less than the usage required for the maximum charge, the reimbursement shall be computed by dividing the hours of usage by

- F. The price-based model reimbursement methodology provides for a facility specific capital cost add-on calculated using the E.H. Boeckh System, a commercial valuation system that estimates the depreciated and non-depreciated replacement cost of a facility.
- G. The Office of Inspector General has required the submission of the Minimum Data Set (MDS) since 1992 and DMS sought to use a tool familiar to the nursing facility industry in order to calculate case-mix. The case-mix portion of the rate will utilize the MDS 2.0 and the Resource Utilization Group (RUG) III to calculate the individual facility's average case-mix.
- H. The case-mix portion of the rate will be adjusted quarterly to reflect the facility's most recent case-mix assessment and to adjust the direct care and non-personnel operation costs (supplies, etc.) portion of the standard price for the current quarter.

SECTION 110. PARTICIPATION REQUIREMENTS

- A. The facilities referenced in Section one hundred (100) shall be reimbursed using the methodology described in 907 KAR 1:065. These facilities shall be licensed by the state survey agency (Office of Inspector General) for the Commonwealth of Kentucky and certified for Medicaid participation by the Department for Medicaid Services.
- B. A nursing facility, except a nursing facility with waiver, choosing to participate in the Medicaid Program will be required to have twenty (20) percent of its Medicaid certified beds participate in the Medicare program or ten (10) of its Medicaid beds participating in the Medicare program whichever is greater. If the NF has less than ten (10) beds all of its beds shall participate in the Medicare Program.
- C. The Medicaid Program shall reimburse all Medicaid beds in a nursing facility at the same rate. The Medicaid rate established for a facility is the average rate for all Medicaid participating beds in that individual facility.

SECTION 100. INTRODUCTION TO PRICE – BASED REIMBURSEMENT SYSTEM

- A. January 1, 2000, a price-based reimbursement system will be implemented to reimburse a nursing facility (NF), a nursing facility with waiver (NF-W), a hospital based nursing facility (NF-HB) and a nursing facility with a mental retardation specialty (NF-MRS Beginning).
- B. The price-based system is a reimbursement methodology based on a standard price set for a day of service as opposed to reimbursing facilities based on the latest submitted cost report. The standard price is based on reasonable, standardized wage rates, staffing ratios, benefits and absenteeism factors and "other cost" percentages.
- C. A rate model was developed which resolves issues inherent in the current system reflects current reimbursement methodology trends and satisfies the needs of the Department and the Provider community. The goal of the price-based methodology was to develop a uniform, acuity adjustment rate structure that would pay a nursing facility the same reimbursement for the same type of resident served. This rate structure accounts for resource utilization and allows rates to increase annually by an appropriate inflationary factor. The rate model is market based and accounts for the higher wage rates urban facilities must pay their employees; therefore the urban average rate is slightly higher than the rural. The rate does not distinguish between hospital based and freestanding facilities.
- D. This payment method is designed to achieve three major objectives:
 - 1. To assure that needed nursing facility care is available for all eligible recipients including those with higher care needs; and,
 - 2. To provide an equitable basis for both urban and rural facilities to participate in the Program; and,
 - 3. To assure Program control and cost containment consistent with the public interest and the required level of care.
- E. The system is designed to provide a reasonable reimbursement for providers serving the same type of residents in the nursing facility and to provide for a reasonable rate of return on the provider's investment.

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13. Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program. A sufficient number of providers assures eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.
14. The Department shall require the submission of the most recent Medicare cost report and the Medicaid Supplemental Schedules included in the manual to be used for historical data.
15. Participation in the program shall be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan.
16. The state will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in this attachment.
17. Payments will be made by Medicaid for Medicare Part A and Part B co-insurance in accordance with Attachment 4.19-B, Supplement 1.

9. Participation in the program is limited to providers of service who accept, as payments in full, the amounts paid in accordance with the State Plan.
10. Payments will be made by Medicaid for Medicare Part A and Part B co-insurance in accordance with Attachment 4.19 B, Supplement 1.

Price-Based Nursing Facilities

The following facilities are reimbursed by the price-based nursing facility methodology:

- a. A free-standing nursing facility;
- b. A hospital-based nursing facility;
- c. A nursing facility with waiver;
- d. A nursing facility with mental retardation specialty; and
- e. A hospital providing swing bed nursing facility care.

Costs Reports for Price-Based Nursing Facilities

Price-based nursing facilities must submit the latest Medicare cost report and the Medicaid supplement schedules attached to Attachment 4.19-D Exhibit-B. The Medicaid Supplement Schedules are utilized for statistical data. The Medicare Supplemental Cost Schedules are utilized for historical data.

The Medicare cost report and Medicaid supplement schedules shall be submitted to the Department pursuant to time frames established in HCFA Provider Reimbursement Manual-Part 2 (PUB. 15-11) Section 102, 102.1, 102.3 and 104.